3 Clinic Guidelines

3.1 Mental Health Clinic Service Policy

3.1.1 Introduction

This section covers all Medicaid services provided by mental health clinics and diagnostic screening clinics. It addresses the following:

- Provider enrollment and Credentialing
- Psychotherapy and diagnostic screening
- Record keeping
- Covered services
- Exclusions
- Reporting requirements
- Claims payment
- Claim billing

Note
Diagnostic Services, PW Clinic, and Speech and Hearing Clinic services are not covered for **CHIP-B** participants.

Refer to the **CHIP-B *Appendix, section B.1.5,*** for service limitations for CHIP-B participants.

3.1.2 Overview

The mental health clinic program is designed to foster better mental health for Medicaid participants. In accordance with the Federal Code of Regulations 42 CFR 440.90, all mental health clinic services must be provided at the clinic, unless provided to an eligible homeless individual per regulations. In most cases, services provided outside of the clinic facility are not reimbursable by Medicaid. Clinic services are typically “preventative, diagnostic, therapeutic, rehabilitative, or palliative” services. Recreational, educational, and vocational services are not Medicaid-covered Mental Health Clinic services.

3.1.2.1 Provider Enrollment and Credentialing

In order to become enrolled as a Medicaid mental health clinic provider the provider applicant must meet the requirements established through the Credentialing Program. All existing mental health clinic providers must meet the requirements of the Credentialing Program on a schedule established with the Department.

All locations where Medicaid mental health clinic services are provided must be registered with the Department and must have a valid provider agreement. Mental health clinics are no longer allowed to bill for services provided at another location under their main clinic number.

3.1.2.2 Physician Requirement

All clinics must have a contract with a medical doctor or doctor of osteopathy in which the doctor agrees to the following:

- See the patient within thirty days of the client first entering the clinic for services (and annually thereafter) in order to determine medical necessity of clinic services
- Review and sign the treatment plan within thirty days and review and sign all updates to the treatment plan that represent a change in treatment

- Spend as much time in the clinic as is necessary to assure that the participant is receiving services in a safe and efficient manner in accordance with accepted standards of medical practice

3.1.2.3 Evaluative or Diagnostic Services

Twelve (12) hours of evaluative or diagnostic services and treatment plan development are payable per calendar year per participant. Note: Medicaid Basic Plan Benefit clients are limited to twenty-six (26) services for *all* non-inpatient Mental Health services combined. The twelve (12) hours of evaluative or diagnostic services count towards the twenty-six (26) service limitation.

3.1.2.4 Psychotherapy

Psychotherapy services, including individual, group, or family psychotherapy including emergency services are limited to no more than forty-five (45) hours per calendar year per participant. **Note:** Medicaid Basic Plan Benefit clients are limited to twenty-six (26) services for *all* non-inpatient Mental Health services combined.

3.1.2.5 Interactive Psychiatric Diagnostic Interview Examinations and Interactive Psychotherapy

Interactive psychiatric diagnostic interview examinations and interactive psychotherapy are typically furnished to children. They involve the use of physical aids and non-verbal communication to overcome barriers to therapeutic interaction between the clinician and a participant. They are used when the participant has not yet developed, or has lost, either the expressive language communication skills to explain his/her symptoms and response to treatment, or the receptive communication skills to understand the clinician if he/she were to use ordinary adult language for communication. Note: Medicaid Basic Plan Benefit clients are limited to twenty-six (26) services for *all* non-inpatient Mental Health services combined.

3.1.3 Partial Care

Partial care is treatment for those whose functioning is sufficiently disrupted so as to interfere with their productive involvement in daily living. Partial care services consist of structured programs of therapeutic interventions that assist a program participant to stabilize his/her behavior and conduct. This is accomplished through the application of principles of behavior modification for behavioral change and structured, goal-oriented group socialization for skill acquisition. The goal of partial care services is to decrease the severity and acuity of presenting symptoms so that the program participant may be maintained in the least restrictive setting and to increase the program participant's interpersonal skills in order to obtain the optimal level of interpersonal adjustment.

Partial care services are payable up to a maximum of thirty-six (36) hours per week per eligible participant. Partial care (day treatment) services must be provided at the clinic by qualified staff listed in IDAPA 16.03.09.465.07. This list does not include support staff. A Mental Health Clinic provider may elect to employ support staff to provide support services to participants. Such support services may include providing transportation, cooking and serving meals, cleaning and maintaining the physical plant or providing general, non-professional supervision. Clinical Services should not be provided by students or aides and services provided by students or aides are not

reimbursable by Medicaid. **Note:** Partial care services are covered for Enhanced Plan participants.

3.1.4 Collateral Contact

Contact may be billed as collateral contact when it is necessary to provide consultation or treatment direction about a Medicaid participant to an individual having a primary treatment relationship to the participant. The need for collateral contact should be clearly reflected in the participant's written treatment plan. The service must be:

- Conducted by agency staff qualified to deliver clinical services
- Authorized on the treatment plan
- Documented in the progress notes
- Face to face

Note: Services not approved in the treatment plan or documented as indicated in **3.1.6** will not be reimbursed by Medicaid.

Collateral contact cannot be used to bill Medicaid for therapy to an ineligible person or be paid on behalf of an individual who is a resident of a public institution or a nursing home including an intermediate care facility for the mentally retarded (ICF/MR).

3.1.5 Exclusions

Mental health clinic services are not covered when provided in an institution.

3.1.6 Record Keeping

Each mental health clinic is required to maintain records on all services provided to Medicaid participants. The record must contain a current treatment plan based on an individual assessment of the participant's needs and signed by a physician within thirty days of the initiation of treatment in the clinic.

Services must be provided in accordance with the current treatment plan, and the records must contain all of the following:

- The exact type of treatment provided
- Who provided the treatment
- The duration of the treatment and the time of day delivered
- Detailed records of exactly what occurred during the therapy session or participant contact documented by the person who delivered the service
- The legible, dated signature, with degree credentials listed of the staff member performing the service

Any service not adequately documented in the participant's record by the signature of the therapist providing the therapy or participant contact, the length of the therapy session, and the date of the contact, will not be reimbursed by the Department.

3.1.7 Procedure Codes

Idaho Medicaid uses the following five-digit codes for mental health clinic services:

Service	CPT or HCPCS Code	Description
Diagnosis and Evaluation		
Medical Report Based on New Exam	90889	*Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other physicians, agencies, or insurance carriers.* This may be billed by: Physician, Nurse Practitioner, Physician Assistant, Psychiatric Nurse Practitioner, or Clinical Nurse Specialist-Psychiatric. Bill with appropriate mental health diagnosis. Reimbursed per report.
Medical Report on Past Record Rather Than New Exam	90885	*Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes.* This service may be billed by: Physician, Nurse Practitioner, Physician Assistant, Psychiatric Nurse Practitioner or Clinical Nurse Specialist-Psychiatric. Must use appropriate mental health diagnosis. Reimbursed per report.
Psychiatric Diagnostic Interview, Exam	90801 U1 modifier is required when provided by physician	*Psychiatric diagnostic interview examination.* This service may be billed by: Physician, Nurse Practitioner, Physician Assistant, Psychiatric Nurse Practitioner, Clinical Nurse Specialist-Psychiatric, Psychologist, Licensed Clinical Social Worker, Licensed Clinical Professional Counselor, or Licensed Marriage and Family Therapist 1 unit = 15 minutes
Interactive Medical Psychiatric Diagnostic Interview, Exam	90802 U1 modifier is required when provided by physician	*Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication.* This service may be billed by: Physician, Nurse Practitioner, Physician Assistant, Psychiatric Nurse Practitioner, Clinical Nurse Specialist-Psychiatric, Psychologist, Licensed Clinical Social Worker, Licensed Clinical Professional Counselor. or Licensed Marriage and Family Therapist 1 unit = 15 minutes
Social History and Evaluation	T1028	*Assessment of home, physical and family environment, to determine suitability to meet patient's medical needs.* Also referred to in rule as Medical Psychosocial History and Intake Assessment. This service may be performed by LSW or RN as well as other qualified clinical staff. This code should be used as part of the initial intake only. It is not considered to be an ongoing service. 1 unit = 15 minutes
Psychological Testing for Diagnosis and Evaluation	96101	*Psychological testing (includes psychodiagnostic assessment of personality, psychopathology, emotionality, intellectual abilities, e.g., WAIS, Rorschach, MMPI)per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report.* 1 unit = 1 hour

Service	CPT or HCPCS Code	Description
Psychological Testing for Diagnosis and Evaluation	96102	*Psychological Testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI and WAIS), with qualified healthcare professional interpretation and report, administered by technician per hour of technician time, face-to-face.* *1 unit = 1 hour*
Psychological Testing for Diagnosis and Evaluation	96103	*Psychological Testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI), administered by computer with qualified healthcare professional interpretation and report,* *1 unit = 1 test*
Individual and Group Psychotherapy		
Individual Medical Psychotherapy	90804 90806 90808 UA modifier is required when provided by physician	*Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient.* (90804) The codes are based on length of time spent with the participant. Providers should select the code that is closest to duration of the session and bill the code as 1 unit. 90804 = 20-30 minutes, 90806 = 45-50 minutes, and 90808 = 75-80 minutes. Reminder: Medicaid does not reimburse for documentation time.
Group Medical Psychotherapy	90853 U1 modifier is required when provided by physician	*Group psychotherapy (other than of a multiple-family group).* 1 unit = 15 minutes
Family Medical Psychotherapy	90847 U1 modifier is required when provided by physician	*Family psychotherapy (conjoint psychotherapy) (with patient present).* 1 unit = 15 minutes
Interactive Individual Medical Psychotherapy	90810 90812 90814 UA modifier is required when provided by physician	*Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient.* (90810) The codes are based on length of time spent with the participant. Providers should select the code that is closest to the duration of the session and bill the code as 1 unit. 90810 = 20-30 minutes, 90812 = 45-50 minutes, and 90814 = 75-80 minutes. Reminder: Medicaid does not reimburse for documentation time.
Interactive Group Medical Psychotherapy	90857 U1 modifier is required when provided by physician	*Interactive group psychotherapy.* 1 unit = 15 minutes
Other Mental Health Codes		

Service	CPT or HCPCS Code	Description
Collateral Contact	90887	*Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient.* This service is reimbursed if face-to-face, necessary to gather information and is included on the participant's treatment plan. Specify person who attended session and relationship to the participant. 1 unit = 15 minutes
Partial Care	H2014	*Skills training and development.* Partial care services are structured program of therapeutic interventions and must be provided at the clinic. This service must be documented on the participant's treatment plan with concrete and measurable goals. The participant is limited to 36 hours per week (Sunday through Saturday). 1 unit = 15 minutes **Note:** Partial care services are covered for Enhanced Plan participants.
Pharmacologic Management	90862	*Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy.* This may be billed by: Physician, Nurse Practitioner, Physician Assistant, Psychiatric Nurse Practitioner or Clinical Nurse Specialist-Psychiatric. 1 unit = 1 visit
Nursing Service	T1001	*Nursing assessment – evaluation; also includes review of lab results, face-to-face physician and/or participant consultation to discuss participant's condition; face-to-face physician contact to obtain prescription refills.* *Note: All services must appear on treatment plan in order to be reimbursed.* 1 unit = 15 minutes
Blood Drawing Fee	36415	*Routine venipuncture for collection of specimen(s).* 1 unit = 1 visit
Medication Injection	90782	*Therapeutic, prophylactic or diagnostic injection (specify material injected); subcutaneous or intramuscular.* Includes nurse time and administration. 1 unit = 1 injection
Medication Supply	J3490	*Unclassified drugs.* Specify medication and dosage. **Use of this code requires submission of the NDC** (National Drug Code) – note the drug code in the comments field of the claim. See Section 3.1.8.1 for instructions.
Occupational Therapy (Individual)	97535	*Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes.* 1 unit = 15 minutes
Interpretation Services		

Service	CPT or HCPCS Code	Description
Non-certified; Partially certified; and Certified	8296A	*Interpretive Services.* (NOTE: Medicaid combined the three previous interpreter codes into one). New code and rate effective for dates of service on or after 8/01/03. 1 unit = 1 hour

3.1.7.1 Reporting National Drug Code (NDC) for Medications Billed with HCPCS Codes

Professional claims for medications reported with HCPCS (Healthcare Common Procedure Coding System) codes, must include the appropriate NDC of the medication supplied, units dispensed, and basis of measurement for each HCPCS medication. This requirement applies to cancer drugs with HCPCS codes, claims submitted electronically and on the paper CMS-1500 claim form. This requirement **does not** apply to Medicare claims which "crossover" to Medicaid as the secondary payer.

The HCPCS medications that require NDC information are listed in the current HCPCS Level II Expert Manual, Appendix 3, alphabetically by both generic, brand or trade name with corresponding HCPCS codes. Claims with incomplete NDC information will be denied with EOB 628 – "NDC required."

The collection of the NDC information allows Medicaid to collect rebates due from drug manufacturers, resulting in significant cost saving to Idaho's Medicaid Program. This requirement is supported by CMS, which encourages all states to develop systems to claim drug rebates due to the Medicaid programs. See State Medicaid Director Letter #03-002, at: **http://www.cms.hhs.gov/states/letters/smd031403.pdf**.

Electronic Claims
For professional providers that use the PES (Provider Electronic Solutions) billing software provided by EDS, a HIPAA compliant field to report the NDC information is included. Providers who are not set up to bill electronically with PES software may contact an EDS provider services representative for more information (toll-free: (800) 685-3757 or (208) 383-4310 in the Boise area).

To enter NDC data in the PES software, complete the Service and RX tab fields using the following guidelines:

SERVICE Tabs:

Complete Service Tabs 1 and 2 as appropriate.

Select Service Tab 3 and complete the appropriate fields.

Enter "Y" in the RX Ind field to open the RX tab.

RX Tab:

Complete the following fields:

NDCL: enter the 11 digit NDC number

Prescription Number: not required.

Units: enter the units dispensed. Refer to the HCPCS manual, Appendix 3, for brief directions regarding the "Amount" (Unit) column.

Basis of Measurement: enter IU – International Units, GR – Grams, ML – Milliliters, or UN

Unit Price: enter the price for the HCPCS medication dispensed

Refer to the PES (Provider Electronic Solution) handbook, Section 9 (837 Professional Forms) for more information on completing the Rx fields. It is available on the Idaho Medicaid Provider Resources CD and can be accessed online at:
http://www.healthandwelfare.idaho.gov/DesktopModules/Documents/DocumentsView.aspx?tabID=0&ItemID=4477&MId=11624&wversion=Staging

Providers using vendor software other than PES will need to confirm with their vendor or clearinghouse that they have successfully tested the professional claim form with EDS and can successfully enter the required data into the correct fields (NDC of medication supplied, units dispensed, and basis of measurement for each HCPCS medication).

Paper Claims
Submission of an *NDC Detail Attachment* is required with paper claim forms when submitting a medication billed with a HCPCS code. For each medication HCPCS code, complete the corresponding detail line on the attachment with the NDC number, description, units dispensed, basis of measurement, and total charges. A copy of the *NDC Detail Attachment* is available in the Forms Appendix and can be used as a master copy. The form can also be found on page 12 at: **www2.state.id.us/dhw/medicaid/MedicAide/1003.pdf**.

Providers can avoid filling out the NDC Detail Attachment by submitting their claims electronically.

3.1.8 Mental Health Clinic Modifiers

Some procedure codes may require a modifier. Refer to the procedure code table listed for the specific modifiers needed.

3.1.9 Place of Service Codes

Enter the appropriate numeric code in the place of service box on the CMS 1500 claim form or in the appropriate field when billing electronically.

11 Office

99 Other place of service - Community (used only when clinic services have been provided to an eligible homeless individual)

3.1.10 Specialized Services to Nursing Facility Participants

Psychotherapy may be provided to a participant residing in a nursing facility if the following criteria are met:

- The participant has been identified through the initial Pre-Admission Screening/Annual Resident Review (PASARR) process as being mentally ill.
- The participant has been identified through the PASARR level II screening process as requiring psychotherapy as a specialized service.
- The participant, when informed of their options for service delivery, chooses a mental health clinic to provide that service.
- The service is provided outside the nursing facility at a *mental health clinic*.

Psychotherapy is:

- Supported by the independent evaluations completed and approved by the Mental Health Authority
- Incorporated into the participant's medical care plan
- Directed toward the achievement of specific, measurable objectives that include target dates for completion

RMS offices are responsible for assuring the participant is identified as needing specialized services and for assigning prior authorization numbers for clinic services. The prior authorization number must be entered on the claims submitted for payment.

3.1.10.1 Procedure Codes for Psychotherapy

All claim forms for psychotherapy to nursing facility participants must include at least one of the following procedure codes:

Service	HCPCS or CPT Code	Description
Individual Psychotherapy to Nursing Facility Participants	H0004 U4 modifier required	*Behavioral health counseling and therapy, per 15 minutes* 1 unit = 15 minutes.
Individual Interactive Psychotherapy to Nursing Facility Participants	90899 U4 modifier required	*Unlisted psychiatric service or procedure*
Group Psychotherapy to Nursing Facility Participants	90853 U4 modifier required U1 modifier is required when provided by physician	*Group psychotherapy (other than of a multiple-family group)* 1 unit = 15 minutes
Family Interactive Psychotherapy to Nursing Facility Participants	90857 U4 modifier required U1 modifier is required when provided by physician	*Interactive group psychotherapy* 1 unit = 15 minutes
Family Psychotherapy to Nursing Facility Participants	90847 U4 modifier required U1 modifier is required when provided by physician	*Family psychotherapy (conjoint psychotherapy) (with patient present)* 1 unit = 15 minutes

3.2 Diagnostic Screening Clinic Service Policy

3.2.1 Overview

Diagnostic screening clinics coordinate the treatment between physicians and other medical professionals for Medicaid participants diagnosed with cerebral palsy, myelomeningitis, or other neurological diseases and injuries with comparable outcomes. The clinic must be established as a separate and distinct entity from the hospital, physician, or other provider practices.

Note: Diagnostic Screening services are not covered for **CHIP-B** or Basic Plan participants.

Refer to the **CHIP-B Appendix, section B.1.5** for service limitations for **CHIP-B** participants.

3.2.2 Multidisciplinary Assessment and Consultation

The clinic must perform an on-site multidisciplinary assessment and consultation with each participant and responsible parent or guardian. Diagnostic and consultation services related to the diagnosis and treatment of the participant are provided by board-certified physicians who are specialists in physical medicine, neurology, and orthopedics.

3.2.3 Service Limitations

As part of a diagnostic assessment, a medical social worker monitors and arranges participant treatments and provides medical information to providers who have agreed to coordinate the care of the participant. The clinic may bill no more than five hours of medical social services per participant during each state fiscal year (July 1-June 30). **Note:** Diagnostic Screening Clinic Services are a covered benefit for Enhanced Plan participants.

3.3 Claim Billing

3.3.1 Which Claim Form to Use

Claims that do not require attachments may be billed electronically using the PES software (provided by EDS at no cost), other HIPAA-compliant vendor software, or a clearinghouse.

- To submit electronic claims, use the HIPAA-compliant 837 transaction.
- To submit claims on paper, use original red CMS-1500 claim forms.

All claims must be received within one year of the date of service.

3.3.2 Electronic Claims

For PES software billing questions, consult the Idaho PES Handbook. Providers using vendor software or a clearinghouse should consult the user manual that comes with their software.

3.3.2.1 Guidelines for Electronic Claims

See **Section 2** for more information on electronic billing.

Detail lines
Idaho Medicaid allows up to **50** detail lines for electronic HIPAA 837 Professional claims.

Referral number
A referral number is required on an electronic HIPAA 837 Professional claim when a participant is referred by another provider. Use the referring provider's Medicaid provider number, unless the participant is a Healthy Connections participant. For Healthy Connections participants, enter the provider's Healthy Connections referral number.

Prior authorization (PA) numbers
Idaho Medicaid allows more than one prior authorization number per electronic HIPAA 837 Professional claim. PAs can be entered at the header or detail of the claim.

Modifiers
Up to **four** modifiers per detail are allowed on an electronic HIPAA 837 Professional claim.

Diagnosis codes
Idaho Medicaid allows up to **eight** diagnosis codes on an electronic HIPAA 837 Professional claim.

Electronic crossovers
Idaho Medicaid allows providers to submit electronic crossover claims for Professional services.

3.3.3 Guidelines for Paper Claim Forms

See **Section 3.3.3.3** for instructions on completing specific fields.

For paper claims, use only original CMS-1500 claim forms (formerly known as the HCFA 1500) to submit all claims to Idaho Medicaid. CMS-1500 claim forms are available from local form suppliers. The CMS-1500 claim form can be used without changes for dates in the year 2000 and beyond. All dates must include the month, day, century, and year.

Example*:* July 4, 2005 is entered as 07/04/2005

3.3.3.1 How to Complete the Paper Claim Form

The following will speed processing of paper claims:

- Complete all required areas of the claim form.
- Print legibly using black ink or use a typewriter.
- When using a printer, make sure the form is lined up correctly so it prints evenly.
- Keep claim form clean. Use correction tape to cover errors.
- Dates are accepted in the month/day/year (MM/DD/YY) format.
- A maximum of six line items per claim can be accepted. If the number of services performed exceeds six lines, prepare a new claim form and complete all the required elements. Total each claim separately.
- You can bill with a date span (From and To Dates of Service) **only if** the service was provided every consecutive day within the span.
- Be sure to sign the form in the correct field. Claims will be denied that are not signed.
- Do not use staples or paperclips for attachments. Stack them behind the claim.
- Do not fold the claim form(s). Mail flat in a large envelope (recommend 9 x 12).
- Send correspondence in a separate envelope or mark the claims envelope, “Correspondence enclosed”.

3.3.3.2 Where To Mail the Paper Claim Form

Send completed claim forms to:

EDS
P.O. Box 23
Boise, ID 83707

3.3.3.3 Completing Specific Fields on the Paper Claim Form

Consult the Use column to determine if information in any particular field is required. Only fields that are required for billing the Idaho Medicaid program are shown on the following table. There is no need to complete any other fields. Claim processing will be interrupted when required information is not entered into a required field.

The following numbered items correspond to the CMS-1500 claim form.

Field	Field Name	Use	Directions
1a	Patient ID	Required	Enter the seven-digit participant ID number exactly as it appears on the plastic participant ID card.
2	Patient’s Name	Required	Enter the participant’s name exactly as it appears on the Medicaid plastic ID card. Be sure to enter the last name first, followed by the first name and middle initial.
9a	Other Insured’s Policy or Group Number	Required if applicable	Required if field 11d is marked YES. If the participant is covered by another health insurance or medical resource, enter the policy number.

Field	Field Name	Use	Directions
9b	Other Insured's Date of Birth/Sex	Required if applicable	Required if field 11d is marked YES. If the participant is covered by another health insurance or medical resource, enter the date of birth and sex.
9c	Employer's Name or School Name	Required if applicable	Required if field 11d is marked YES.
9d	Insurance Plan Name or Program Name	Required if applicable	Required if field 11d is marked YES. If the participant is covered by another health insurance or medical resource, enter the plan name or program name.
10a	Is Condition Related to Employment?	Required	Indicate yes or no if this condition is related to the participant's employment.
10b	Auto Accident?	Required	Indicate yes or no if this condition is related to an auto accident.
10c	Other Accident?	Required	Indicate yes or no if this condition is related to an accident.
11d	Is There Another Health Benefit Plan?	Required	Check yes or no if there is another health benefit plan. If yes, return to and complete items 9a-9d.
14	Date of Current: Illness, Injury or Pregnancy	Desired	Enter the date the illness or injury first occurred, or the date of the last menstrual period (LMP) for pregnancy.
15	If Patient Has Had Same or Similar Illness	Desired	If yes, give first date, include the century. For pregnancy, enter date of first prenatal visit.
17	Name of Referring Physician or Other Source	Required if applicable	Use this field when billing for a consultation or Healthy Connections participant. Enter the referring physician's name.
17a	ID Number of Referring Physician	Required if applicable	Use this field when billing for a consultation or Healthy Connection participant. Enter the referring physician's Medicaid provider number. For Healthy Connections participants, enter the provider's Healthy Connections referral number.
19	Reserved for Local Use	Required if applicable	If applicable, all requested comments for claim submission should be entered in this field. For example, enter injury information, including how, when, and where the injury occurred if another party is liable. This field can also be used to enter the ICN of previous claims to establish timely filing.
21 (1-4)	Diagnosis or Nature of Illness or Injury	Required	Enter the appropriate ICD-9-CM code (up to 4) for the primary diagnosis and, if applicable, second, third, and fourth diagnosis. Enter a brief description of the ICD-9-CM primary and, if applicable, second, third, and fourth diagnosis.
23	Prior Authorization Number	Required	Enter the prior authorization number from DHW, RMS, ACCESS, RMHA, EDS, Quality Improvement Organization (QIO), or MT.
24A	Date of Service — From/To	Required	Fill in the date(s) the service was provided, using the following format: MMDDCCYY (month, day, century, and year). **Example:** November 24, 2005 becomes 11242005 with no spaces and no slashes.
24B	Place of Service	Required	Enter the appropriate numeric code in the place of service box on the claim.
24D 1	Procedure Code Number	Required	Enter the appropriate five-character CPT or HCPCS procedure code to identify the service provided.

Field	Field Name	Use	Directions
24D 2	Modifier	Required if applicable	If applicable, add the appropriate CPT or HCPCS modifier(s). Enter as many as three. Otherwise, leave this section blank.
24E	Diagnosis Code	Required	Use the number of the subfield (1-4) for the diagnosis code entered in field 21.
24F	Charges	Required	Enter your usual and customary fee for each line item or service. Do not include tax.
24G	Days or Units	Required	Enter the quantity or number of units of the service provided.
24H1	EPSDT (Health Check) Screen	Required if applicable	Not required unless applicable. If the services performed constitute an EPSDT program screen, refer to the instructions for EPSDT claims in the provider handbook.
24I	EMG	Required if applicable	If the services performed are related to an emergency, mark this field with an **X**.
24K	Reserved for Local Use	Required if applicable	When a group, agency, or clinic is the billing agency, enter the Idaho Medicaid provider number of the provider rendering the service in Field 24K and the group provider number in field 33 GRP #.
28	Total Charge	Required	Add the charges for each line then enter the total amount.
29	Amount Paid	Required	Enter any amount paid by other liable parties or health insurance payments including Medicare. Attach documentation from an insurance company showing payment or denial to the claim.
30	Balance Due	Required	Enter the total charges, less amount entered in amount paid field.
31	Signature and Date	Required	The provider or the provider's authorized agent must sign and date all claims. If the provider does not wish to sign or signature stamp each individual claim form, a statement of certification must be on file at EDS. See Section 1.1.4 for more information.
33	Provider Name and Address	Required	Enter your name and address exactly as it appears on your provider enrollment acceptance letter or RA. If you have had a change of address or ownership, please, immediately notify Provider Enrollment, in writing, so that the Provider Master File can be updated.
33	GRP # — Group Provider Number PIN # --- Individual Provider Number	Required	Enter your nine-digit Medicaid provider number.

3.3.3.4 Sample Paper Claim Form

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statement on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)
APPROVED OMB-0938-0008

PLEASE PRINT OR TYPE

FORM CMS-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500